CO-OCCURRING DISORDERS SERVICE DELIVERY QUALITY INITIATIVE WORKGROUP MEETING MINUTES

Meeting Chair:	Blaine Shaffer, M.D.	*Attendees: Ann Tvrdik, Dr. Blaine Shaffer, Dr. Cameron White, Diana Meadors, Dr. Donna Polk-Primn*
Meeting Date:	May 3, 2010	*Jean Sassatelli, Jo Ann O'Connell, Julie Scott, Dr. Kathleen Grant, Linda Wittmuss, Margaret Van Dyke, Mary O'Hare, Paula Eurek, Rand Wiese, Dr. Rick McNeese, Sheri Dawson, Sue Adams, Dr. Susan Boust, Tara Muir, Teresa Campbell, Topher Hansen, Dr. Vijay Dewan, Abigail Anderson*
Meeting :	*Region 5 Systems*	*Attachments:*
Meeting:	Co-Occurring Disorders Service Delivery Workgroup	*All Attachments were placed in the Members' notebooks.*

Topic/Issue	*Discussion*	*Recommendations/ Action*	*Resp. party*	*Due Date*	*Status*
Introductions	Each member introduced themselves and spoke about their experience and interest related to co-occurring disorders.				
Overview	Chair Blaine Shaffer and Sheri Dawson gave an overview of the project. Members were provided with a notebook with background information and reference materials. Mission Statement: The Co-Occurring Disorders Quality Initiative will improve services to Nebraska adults with co-occurring mental health and substance use disorders and their families. Goal: The Co-Occurring Disorders Workgroup will produce a roadmap to a statewide, integrated co-occurring service delivery system. Statewide Quality Improvement Team (SQIT): Sheri Dawson discussed the Statewide Quality Improvement Team (SQIT). All six Regional Behavioral Health Authorities have a Quality Improvement Team. Almost 50% of the people involved are consumers. There is also a Magellan (MQIT), a Statewide (SQIT) and a Data (DQIT) team. SAMSHA Co-Occurring Disorders Initiative: This is a national initiative to promote integrated, co-occurring services. Overview Papers have been developed to assist in guiding the initiative. The Overview Papers were distributed to the Workgroup and are to be utilized as references. Some states were awarded Federal grants to create action plans for the development of integrated co-occurring disorder services. The Nebraska workgroup will use the same action plan template used by the funded				

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	states to create a roadmap for integrated co-occurring services for Nebraska. The Nebraska Workgroup's efforts will serve as a foundation for future grants associated with co-occurring disorders. Nebraska's Integrated Co-Occurring System Roadmap Development**:** Chair Blaine Shaffer discussed workgroup member responsibilities. Workgroup members are responsible for promoting recovery of individuals and families by creating a statewide road map to an integrated co-occurring service delivery system. SAMSHA's Co-Occurring Center for Excellence (COCE) Content Framework will be utilized as the basis for the committee's work. The Content Framework includes: Definitions, Principles, and Epidemiology; Screening, Assessment, Treatment Planning, and Treatment Services; Workforce Issues; Systems Issues; Prevention and Early Intervention; and Evaluation and Monitoring. Subcommittees will be formed to develop strategies and actions which correspond to the Content Framework. Subcommittee members will be determined according to interests of the members. Members are asked to submit their priority interests by completing the personal profile form if they haven't already. Nebraska's Roadmap will be shared with a wide variety of stakeholders to include at a minimum the RBHA Quality Improvement Teams, State Advisory Committees, providers of behavioral health services, consumers, advocacy organizations, Department of Correctional Services, and other interested members of the public for input. The Roadmap will be revised accordingly and presented to DBH for further revision and subsequent approval and implementation.	Workgroup Member Expectations • Attend 15 monthly meetings • Review materials assigned • Seek input and recommendations from interested individuals, organizations, and groups • Serve on a minimum of one Subcommittee Subcommittee Expectations • Review COCE Content Framework Related Information • Research other literature related to topic area • Review other states' progress in the area • Present findings to the larger workgroup • Propose statewide strategies • Lead discussion with larger workgroup • Seek feedback from	Members	Ongoing	

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		other stakeholders Another personal profile form will be emailed out to members. Members are asked to complete personal profile forms and email to abigail.anderson@nebraska.gov	DBH staff Members	ASAP 5/11/10	
Definitions and Terms Related to Co-Occurring Disorders	Definitions and Terms Relating to Co-Occurring Disorders Overview Paper 1. The definitions to be utilized in this project can be found in Overview Paper 1. The "No Wrong Door" concept was discussed. The Nebraska Roadmap will guide Nebraska to an integrated behavioral health system where consumers can receive services for both mental health and substance abuse disorders regardless of the service door entered. The challenge of how Nebraska prepares, trains and educates clinicians to be able to work with people with co-occurring disorders was recognized. Also, how the licensing requirements and types of licenses affect co-occurring services and funding is another question that needs to be explored.				
Overarching Principles	Overarching Principles to Address the Needs of Persons with Co-Occurring Disorders (Overview Paper 3.) Based on their experience and perception, workgroup members completed a survey grading (A, B, C, D, F) Nebraska's status on each principles. Results follow. **Principle 1: Co-occurring disorders are to be expected in all behavioral health settings, and system planning must address the**				

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	need to serve people with COD in all policies, regulations funding mechanisms, and programming. Nebraska's Grade: Mostly Ds This statement implies a system and NE doesn't have a co-occurring system. As a system Nebraska has an expectation that is higher but in practice it is not happening across the state. **<u>Principle 2:</u> An integrated system of mental health and addiction services that emphasizes continuity and quality is in the best interest of consumers, providers, programs, funders, and systems.** Nebraska's Grade: Mostly Cs Nebraska has limited resources but providers work hard at quality and continuity of care for the consumers served. Some providers still really struggle at the service-provider level. A desire for continuity and quality exists, but currently there is no integrated system. **<u>Principle 3:</u> The integrated system of care must be accessible from multiple points of entry (i.e., no wrong door) and be perceived as caring and accepting by the consumer.** Nebraska's Grade: Mostly Ds Professionals have awareness for consumer need, but the infrastructure for an integrated system does not exist. Professionals screen but a way to follow up is not always available. **<u>Principle 4:</u> The system of care for COD should nt be limited to a single "correct" model or approach.** Nebraska's Grade: Mostly As There are so many different approaches that people are using. Some members gave this a D because of a perception that there needs to be more creativity, more integration in services and not just clinical services. **<u>Principle 5:</u> The system of care must reflect the importance of the partnership between science and service, and support both the application of evidence-and consensus-based practices for persons**				

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	with COD and evaluation of the efforts of existing programs and services. Nebraska's Grade: Mostly Ds Some models being utilized are evidence-based, but others are opinion or experience-based. The latter are more often defended vehemently because that clinician is personally attached to the model. Consumers may not always feel welcome, but also providers may not always feel competent to practice and deliver both MH and SA services. It is a culture clash between MH and SA providers. At least right now there is dialogue beginning between the two fields. **<u>Principle 6:</u> Behavioral health systems must collaborate with professionals in primary care, human services, housing, criminal justice, education, and related fields in order to meet the complex needs of persons with COD.** Nebraska's Grade: Mostly Cs There is an effort by BH systems to work with other areas such as primary care, human services, housing, criminal justice, education and other related fields. There needs to be more case managers working with providers to help connect all of these fields. Problem gambling area does work with legal, housing, finance, etc. State legislation needs to be changed, and/or federal rules need to be changed to better accommodate working together. **<u>Principle 7:</u> Co-occurring disorders must be expected when evaluating any person, and clinical services should incorporate this assumption into all screening, assessment, and treatment planning.** Nebraska's Grade: Mostly Cs. Some providers are performing better than others. Stigma is a barrier, some people have a substance abuse problem but then when they find out they also have a MH problem it is surprising and upsetting, or vice versa. Some clinicians' training is compartmentalized and they are not adequately trained to meet the needs of a consumer with a co-occurring disorder. **<u>Principle 8:</u> Within the treatment context, both co-occurring**				

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	disorders are considered primary. Nebraska's Grade: Mostly Ds Currently to receive funding for services, providers have to label one diagnosis as primary and the other secondary. **<u>Principle 9</u>: Empathy, respect, and belief in the individual's capacity for recovery are fundamental provider attitudes.** Nebraska's Grade: C+ Most people do show empathy and respect toward consumers' ability for recovery. Research has shown the relationship between the provider and consumer is the highest determinant of a successful recovery. On the other hand, many programs are not recovery-oriented. **<u>Principle 10:</u> Treatment should be individualized to accommodate the specific needs, personal goals, and cultural perspectives of unique individuals in different stages of change.** Nebraska's Grade: Mostly Ds Multiple models, for multiple different issues, must be utilized, professionals need better training. Academic providers need to educate clinicians on how to write treatment goals and plans to promote successful consumer outcomes. The Workforce subcommittee will be an appropriate forum to discuss how to encourage providers to develop and utilize quality improvement strategies. **<u>Principle 11:</u> The special needs of children and adolescents must be explicitly recognized and addressed in all phases of assessment, treatment planning, and service delivery.** Nebraska's Grade: Mostly Ds Transition to the adult system is an issue with children that have been involved in the different programs and services. They are aging out and then get lost and don't get the services they need as adults. We must begin to start treating the whole family, children included.				

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	<u>Principle 12:</u> The contribution of the community to the course of recovery for consumers with COD and the contribution of consumers with COD to the community must be explicitly recognized in program policy, treatment planning, and consumer advocacy. Nebraska's Grade: Mostly Bs Nebraska is starting to have consumers at the table. Many times it is only after years of recovery that consumers can have time or energy to attend meetings to offer input. It can be difficult, time consuming and exhausting just to influence and advocate for your own treatment plan. Therefore there are many different levels of consumer involvement, not just on an advisory committee level. The workgroup also discussed whether the consumer community is adequately recognized at a policy level or advocacy level in Nebraska. **<u>Conclusion:</u>** Chair Blaine Shaffer asked the group if they could adopt the 12 Overarching Principles to Address the Needs of Persons with Co-Occurring Disorders to guide the development of Nebraska's Roadmap. The members agreed. Further distribution of the Overarching Principles' survey completed by the Workgroup was tabled at this time.				
Homework Assignments	None announced at the meeting.				
Adjournment & Next Meeting	The meeting was adjourned at 4:30 pm. Next meeting: 1:30 to 4:30 June 7, 2010 Region V Systems office.				

Respectfully submitted,

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(Name of minute's taker) (Date)

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(Name of Chair) (Date)